

Publications

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CMS Announces Wide-Ranging Fraud Crackdown

Key Takeaways:

- Centers for Medicare & Medicaid Services (CMS) deferred \$259.5 million in federal Medicaid funds to Minnesota over program integrity concerns.
- CMS will impose a six-month nationwide moratorium on new enrollments for certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers.
- CMS issued a Request for Information seeking stakeholder feedback under its CRUSH initiative to strengthen and expand fraud prevention tools, signaling a wide range of possible new anti-fraud measures.

On Feb. 25, 2026, Vice President J.D. Vance, HHS Secretary Robert F. Kennedy, Jr. and CMS Administrator Dr. Mehmet Oz announced a series of actions aimed at strengthening program integrity across Medicare and Medicaid. The Administration characterized the initiative as part of a broader affordability strategy focused on preventing fraud, waste and abuse before improper payments occur.

“CMS is done trying to catch fraudsters with their hands in the cookie jar – instead, we’re padlocking the jar and letting them starve,” said Administrator Oz. Secretary Kennedy stated that CMS is moving away from a retrospective “pay and chase” model and toward a real-time “detect and deploy” strategy that leverages advanced data analytics and artificial intelligence to identify and stop suspicious payments before funds are disbursed.

Minnesota Medicaid Funding Deferral

CMS deferred \$259,505,491 in federal Medicaid matching funds associated with Minnesota’s fourth quarter FY 2025 expenditures. The deferral follows CMS’s January 2026 notice to the state indicating concerns regarding program integrity and deficiencies in the state’s corrective action plan.

According to CMS, the deferred amount includes \$243.8 million tied to unsupported or potentially fraudulent Medicaid claims; and \$15.4 million associated with claims involving individuals lacking satisfactory immigration status.

Related People

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Related Capabilities

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CMS cited unusually high spending and rapid growth in certain service categories, including personal care services, home and community-based services and other practitioner services. The agency stated that it will continue reviewing the state's compliance and may defer more than \$1 billion in federal funds over the next year if deficiencies are not addressed.

In response to the deferral, on March 2, 2026, the State of Minnesota filed a federal lawsuit against CMS and the U.S. Department of Health and Human Services, alleging the Agency and Department are unlawfully attempting to withhold \$243 million in Medicaid payments owed to the state and seeking immediate relief to restore the suspended funds.

Nationwide DMEPOS Enrollment Moratorium

CMS announced a six-month nationwide moratorium on new Medicare enrollments for certain DMEPOS companies. The moratorium applies to initial enrollment applications and changes in majority ownership. The agency noted that it prevented approximately \$1.5 billion in suspected fraudulent DMEPOS billing in 2025 and intends to use the moratorium period to implement additional safeguards targeting longstanding vulnerabilities in this sector.

CMS also plans to publish identifying information – including National Provider Identifiers (NPIs) and reasons for revocation – for providers and suppliers whose Medicare billing privileges have been revoked. CMS stated that this additional transparency is intended to assist beneficiaries, private payers and other stakeholders in identifying sanctioned entities.

For a deep dive on the DMEPOS enrollment moratorium, read our e-alert [here](#).

CRUSH Initiative:

The announcement also includes a Request for Information (RFI) under CMS's Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) initiative. The RFI was published on Feb. 27, 2026, and seeks input from states, providers, suppliers, payers, technology companies, patient advocates, beneficiaries and other stakeholders on strengthening CMS's authorities and regulatory tools to prevent, detect and respond to fraud and program inefficiencies across Medicare, Medicaid, CHIP and the Marketplace. The RFI is the first step in implementing the new CRUSH initiative, which CMS has said could lead to further rulemaking and programmatic changes, depending on feedback from stakeholders.

Specifically, CMS is requesting comments on topics including:

- **Program integrity and payment suspension authority:** Granting CMS authority to require Medicare Advantage (MA) organizations and Part D sponsors to impose payment suspensions. CMS is also considering changes to enrollment, revocation, audit, medical review and investigation policies to more quickly remove bad actors and improve payment accuracy across Medicare, Medicaid, CHIP and the Marketplace.
- **Enhanced identity proofing ownership standards:** Strengthening screening of individuals with ownership interests in Medicare-enrolled entities, including potential citizenship or lawful permanent residency requirements for 5% or greater owners, and expanded fingerprinting and background checks.
- **Preclusion list and MA enrollment requirements:** Preventing providers revoked from Traditional Medicare from billing MA plans and potentially requiring enrollment in Traditional Medicare as a condition of MA participation.
- **Laboratory and genetic testing oversight:** Expanding regulatory authorities and

potentially broadening the mandatory Molecular Diagnostic Services Program registration beyond its current 28-state footprint to strengthen oversight of laboratory and molecular diagnostic testing.

- **Non-participating DMEPOS suppliers in MA:** Mandating non-participating DMEPOS suppliers in MA to meet the same accreditation, enrollment and compliance standards that apply under traditional Medicare.
- **Medicare claims (Part A and B):** Decreasing the Medicare claims filing deadline from one year to 90-180 days for certain items, services or provider types.
- **Beneficiary solicitation:** Extending existing restrictions on unsolicited DMEPOS outreach to additional provider and supplier types and to newer communication platforms such as email, text messaging and social media.
- **Surety bonds:** CMS is assessing whether to increase minimum bond amounts for DMEPOS suppliers, broaden bond requirements to additional provider types and establish surety bond requirements within Medicaid and CHIP.
- **AI in MA and hospital billing oversight:** Deploying AI and machine learning tools to strengthen medical review, improve coding oversight and enhance real-time fraud detection in Medicare Advantage and hospital billing, with appropriate human oversight.
- **Beneficiary contact and pre-payment outreach:** CMS is considering implementing or expanding pre-payment outreach to beneficiaries when claims appear suspicious and enhancing reporting mechanisms to encourage earlier identification of potential fraud.
- **Medicaid and CHIP program integrity and state flexibility:** Strengthening CMS oversight tools such as more frequent provider revalidation and expanded use of AI as well as providing states additional authority and incentives to proactively combat fraud.

The RFI signals that CMS is focused on increasing real-time fraud detection, and tightening program participation requirements. Providers and investors should view this as an early indicator of heightened screening, enrollment scrutiny, data analytics expansion and cross-program enforcement alignment. Many of the contemplated changes could significantly affect compliant providers through expanded screening and data-driven oversight. As such, providers and other stakeholders should submit comments addressing operational feasibility and due process protections. CMS is accepting public comments on the CRUSH RFI until March 30, 2026.

Should you have questions regarding the information discussed, please reach out to Ben Wallfisch, Ronke Fabayo, Gulnara Anzarova, or your preferred Polsinelli attorney.